Care Coordination Program (CCP)

Mission:

- Provide intensive case management for the **most complex** Medicaid beneficiaries in accessing clinically appropriate health care services, in furtherance of a medical home;
- Coordinate the efficient delivery of health care to this population by removing barriers, bridging gaps, and avoiding duplication of services;
- Educate, encourage and empower this population to eventually self-manage their chronic conditions.

Goal:

- Facilitate the beneficiary-provider relationship by offering services that assist providers in tending to the intricate medical and social needs of beneficiaries without increasing the administrative burden.
- Support providers by providing intensive case management to the beneficiary between visits to achieve the plan of care.
- Improve health outcomes and decrease inappropriate utilization of services.

Method:

- Focus on Medicaid's highest utilizers with chronic conditions, approximately 1,200 beneficiaries statewide annually.
- Emphasize evidence-based, planned, integrated and collaborative care for Medicaid beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room (ER) and inpatient utilization.

Enhanced Reimbursement for Participating Providers:

- Strategy has been developed to reimburse the Primary Care providers assigned as the medical home for the Primary Care Plus beneficiary with an enhanced capitated payment rate of $15 per month for each beneficiary enrolled in CCP.
- The OVHA will also reimburse the provider $55 for the initial plan of care meeting and an additional $55 for the discharge summary meeting.

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